Rhode Island Injury Prevention Plan

2005

SAFE RHODE ISLAND
OFFICE OF HEALTH PROMOTION
RHODE ISLAND DEPARTMENT OF HEALTH

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Safe and Healthy Lives in Safe and Healthy Communities

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Development of the recommendations would not have been possible without the support of the Injury Community Planning Group. We would like to thank them for their considerable guidance.

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EXECUTIVE SUMMARY

Injury is the fifth leading cause of death for Rhode Islanders of all ages, and the leading cause of death for Rhode Island residents aged 44 and younger [1]. Only heart disease, cancer, cerebrovascular disease, and chronic lower respiratory diseases killed more Rhode Islanders during the years 1992 – 2002 [1]. The costs of injuries are staggering – billions of dollars in health care and social support resources. In 1999-2002, there were 1,849 fatal injuries, or an average of 462 fatal injuries per year in Rhode Island [1]. The average annual cost of fatal injuries alone in Rhode Island was over $1.3 billion [2]. This estimate does not include the emotional burden resulting from the loss of a child or loved one, or the toll of disability on an injured person and his or her family.

Mission: The primary mission of the Rhode Island Department of Health is to prevent disease and to protect and promote the health and safety of the people of Rhode Island.

Vision: All people in Rhode Island will have the opportunity to live a safe and healthy life in a safe and healthy community.

HEALTH leadership recognizes that the development and implementation of strategies and action plans can increase years of healthy life and positively impact the quality of life of Rhode Island residents. Recommendations are based upon the most recent information available about the victims and consequences of injury in Rhode Island, with the purpose of informing and enhancing Health Department injury prevention efforts, as well as the efforts of our community collaborators. Recommendations are broad reaching and comprehensive to encourage implementation by as many key stakeholders in injury prevention as possible. Objectives and recommendations are not time framed in recognition of the fact that effective program implementation is often dependent on available resources. SRI will engage community partners in two key activities to move the state injury prevention plan forward: 1) Priority setting; and 2) Developing funding strategies to support infrastructure implementation and interventions.

In October of 2003, Director of HEALTH Patricia Nolan, M.D., convened a Blue Ribbon Panel to determine priorities and strategies for preventing injuries and to guide the development of a statewide injury prevention plan. A community planning group will identify priorities, and specific time frames and targets will be established.

The following are priority objectives identified within each injury area:

I. Motor Vehicle/Transportation Injury Prevention Task Force Recommendations:

Motor vehicle crashes are the leading cause of unintentional injury deaths for Rhode Islanders ages 10-64, and account for 57% of unintentional injuries among individuals aged 18 and younger [1]. Plan recommendations focus on six key areas identified as "best practices" that must be addressed to decrease the burden of motor vehicle crashes in our state.

Key Groups:
Males 16-34, Senior Adults, and Minorities

SRI Goal:
Reduce deaths and injuries caused by motor vehicle crashes.

A Healthier Rhode Island by 2010 Goal:
Reduce deaths caused by motor vehicle crashes from 9 per 100,000 to 7 per 100,000.

Injury Prevention Recommendations: Motor Vehicles

Objective 1 (Occupant Protection): Increase the percentage of people who always use safety belts and the percentage of children using age-appropriate child restraints and seated in the correct position in a motor vehicle.

Objective 2 (Speeding): Reduce the percentage of people who use excessive speed on Rhode Island roadways.

Objective 3 (Impaired Driving): Reduce the number of medically impaired, alcohol-related, and fatigue impaired motor vehicle deaths and injuries.

Objective 4 (Pedestrian): Reduce the number of pedestrian deaths and injuries.

Objective 5 (Bicycle): Reduce the number of bicycle-related deaths and injuries.

Objective 6 (Motorcycle): Increase the percentage of operators and passengers who always use a motorcycle helmet.

II. Fall Injury Prevention Task Force Recommendations:

Falls are the leading cause of unintentional injury death for Rhode Islanders over the age of 65, and account for 66% of all accidental deaths in this age group [1]. For women over the age of 65, falls are the leading cause of injury hospitalization, accounting for 82% of the injury

admissions in 2000 [11]. Plan recommendations focus on four key areas identified as "best practices" that must be addressed to decrease the burden of fall injuries in our state.

Key Group: Senior adults (65-85+) living in the community

SRI Goal: Prevent falls and resulting injuries to senior adults living in the community.

***Healthy People 2010* Goals:**

Reduce deaths from falls from 4.7 per 100,000 to 3.0 per 100,000.

Reduce hip fractures for females ages 65+ from 1,056 per 100,000 to 416 per 100,000; and for males 65+ from 593 per 100,000 to 474 per 100,000

A Healthier Rhode Island by 2010 Goal:
Increase the proportion of adults who engage regularly in moderate physical activity, preferably daily, for at least 30 minutes a day from 22% to 30%.

Injury Prevention Recommendations: Falls

Objective 1 **(Exercise): Increase the percent of senior adults who exercise on most days of the week to reduce the risk of falls and resulting injuries.**

Objective 2 **(Physical Environment): Improve the safety of the physical environment in senior adult homes.**

Objective 3 **(Health Conditions): Improve the management of health conditions that place senior adults at increased risk of falls and resulting injuries.**

Objective 4 **(Medication Management): Increase the percentage of senior adults who have medication reviews to promote medication management.**

III. Suicide Prevention Task Force Recommendations:

Suicide is the leading cause of intentional injury death in Rhode Island [1]. Overall, it is the third leading cause of death for Rhode Island youth (those aged 24 years and younger) and the leading cause of injury-related death for Rhode Island adults aged 25 - 59[1]. Among State elders, suicide is the second leading cause of injury-related death [1]. With the aging baby boom generation, the numbers of suicide attempts and completions are expected to increase in the coming years among the older population. Plan recommendations focus on seven key areas identified as "best practices" that must be addressed in order to decrease the burden of suicide in our state.

Key Groups:

1. Males 25–45
2. Youth 15-24
3. Older Adults 60+

SRI Goals:

1. Reduce the completed suicide rate
2. Reduce suicide attempts

***A Healthier Rhode Island by 2010* Goal:**

Reduce the suicide rate from 10 per 100,000 to 4 per 100,000.

Increase the proportion of adults with recognized depression who receive treatment from 51% to 75%.

Injury Prevention Recommendations: Suicide

Objective 1 **(Awareness): To support and affirm people at-risk for death by suicide.**

Objective 2 **(Awareness): To reduce the stigma associated with having a mental illness and/or seeking services for mental health, substance abuse, and suicide prevention.**

Objective 3 **(Intervention): To improve and expand mental health services delivery.**

Objective 4 **(Intervention): To increase screening and identification.**

Objective 5 **(Intervention): To promote efforts to reduce access to lethal means and methods of self-harm.**

Objective 6 **(Methodology): To coordinate and expand public health surveillance of suicide and suicide attempts.**

Objective 7 **(Methodology): To promote and support culturally relevant research on suicide and suicide prevention**.

IV. Rhode Island Injury Prevention Infrastructure Recommendations:

The leadership of the Rhode Island Department of Health has shown ongoing support for injury prevention despite the lack of a state mandate or resources to sustain injury prevention efforts. Safe Rhode Island is the program designated to provide coordination for injury prevention activities within the Health Department. Injury prevention programs have been maintained through periods of no federal funding and in the absence of state funding. To sustain an injury prevention program over time it is necessary to work with our partners to secure funding that is both adequate to support core injury prevention functions - data

collection, analysis, and dissemination; intervention design, implementation and evaluation; provision of technical support and training; promotion of proven effective policies – and commensurate with the nature and scope of the injury problem in our state.

Injury Prevention Recommendations: Infrastructure

Objective 1 (Infrastructure): Improve the ability of Rhode Island to support injury prevention interventions.

RHODE ISLAND INJURY PREVENTION PLAN 2005

INTRODUCTION

Injury is the fifth leading cause of death for Rhode Islanders of all ages, and the leading cause of death for Rhode Island residents aged 44 and younger [1]. Only heart disease, cancer, cerebrovascular disease, and chronic lower respiratory diseases killed more Rhode Islanders during the years 1992 – 2002 [1]. Each year, thousands of Rhode Islanders are hospitalized due to injury-related causes. For persons under the age of 40, injury is the most common cause of hospitalizations [1]. The financial costs of injuries are staggering - injuries cost billions of dollars in health care and social support resources. In the United States in the year 2000, the total cost (in 2003 dollars) of hospitalized and fatal injuries combined based on incidence was $1.1 trillion [2]. Hospital injuries are the $943.6 billion, and fatal injuries are 47%. (Please note non-admitted injuries are not included in the $1.1 trillion) [2]. In 1999-2002, there were 1,849 fatal injuries, or an average of 462 fatal injuries per year in Rhode Island [1]. The average annual cost of fatal injuries alone was over $1.3 billion. The average cost per case for each fatal injury was $1.8 million[2]. This breaks down as follows: medical $11.5 thousand; productivity $964.7 thousand; and quality of life $807.5 thousand [2]. Estimates do not include the emotional burden resulting from the loss of a child or loved one, or the toll of severe disability on the injured person and his or her family.

Unlike some other public health prevention activities where monitoring, intervention and evaluation occur primarily within the health system, injury prevention involves education, social services, law enforcement, criminal justice, mental health, housing and many other sectors, not to mention the important role of community-based coalitions and organizations.

The Rhode Island Department of Health received a three-year cooperative agreement in 2002 from the US Centers for Disease Control and Prevention (CDC) to assess and plan for injury prevention in the state. The development of the Rhode Island Injury Advisory Council (IAC) was one of the first needs to be addressed. The IAC was formed by Director of Health Dr. Patricia A. Nolan in 2003 and charged with two tasks: setting state level priorities around strategies for preventing injuries; and guiding the development of a state

plan that reflects statewide, population-based level recommendations. Dr. Nolan appointed community leaders as IAC members: Mrs. Suzanne Carcieri, First Lady of Rhode Island; The Honorable Patrick Lynch, Rhode Island Attorney General; Dr. Pablo Rodriguez, Chairman of the Board, The Rhode Island Foundation: Thomas Izzo, former Rhode Island State Senator; and Ms. Trudy Coxe, Chief Executive, Newport County Preservation Society. The IAC identified the three injury prevention priority areas for the state; 1) Unintentional Motor vehicle/ transportation, 2) Unintentional Falls, and 3) and Suicide. Three task forces charged with developing strategic recommendations, with a membership of key stakeholders, were convened between April and December 2004. The Rhode Island Department of Health collaborated with other government agencies, local organizations, and community coalitions including professionals from child and adolescent health, traffic safety, emergency medical services, health care, education, law enforcement, fire prevention, social services, SAFE KIDS coalitions, and others to maximize injury planning and prevention efforts. (Task Force Membership lists are included in Appendix A.) Recommendations from each Task Force were presented to the IAC. Upon approval, the recommendations formed the core of the state Injury Prevention Plan that this document presents.

This Plan provides priorities, target populations and measurable goals for the prevention of motor vehicle/ transportation injury, fall injury, and suicide, and identifies task forces of interested and excited community partners to work with. These priorities and goals are already having an impact on Rhode Island's injury prevention and control effort.

- The Attorney General's Task Force is addressing motor vehicle/transportation injury prevention recommendations on impaired driving. Recommendations were incorporated into the revisions of the state transportation plan that directs transportation expenditures. The Office on Highway Safety and the Bicycle and Pedestrian Safety program are also promoting those recommendations.
- Mental Health, child protection, and substance abuse communities are key partners in suicide prevention and are promoting suicide prevention strategies. The RI Training School is implementing some of the youth suicide recommendations with its gatekeeper training initiative. Recommendations were incorporated into a 2005 proposal for funding from the Providence Center to the US Substance Abuse and Mental Health Administration.
- Fall prevention is focused on the elderly, with the Office of the Lt. Governor Long Term Care Coordinating Council (LTCCC) and Department of Elderly Affairs providing leadership, as well as the University of Rhode Island pharmacy, physical therapy, nursing and exercise science programs. Since 2004,The LTCCC and URI have begun implementing some of the falls recommendations by providing professional development opportunities for elder health care providers.

ACKNOWLEDGMENTS

The Advisory Council would like to acknowledge the Rhode Island Department of Health's (HEALTH) Safe Rhode Island (SRI) staff support in facilitating the planning process. Special recognition and thanks should be made to members of the Task Forces for their dedication to injury prevention.

SRI would like to acknowledge the Children's Safety Network Economic and Insurance Resource Center and the State and Territorial Injury Prevention Director's Association for their support and assistance in data analysis and reviewing the state plan.

USE OF THE STATE PLAN

The goals, objectives, and recommendations will be used by the Department of Health, Safe Rhode Island and all agencies and individuals in Rhode Island working to decrease the burden of injury in our state. The contents of the plan may in whole or in part, be reproduced, copied, disseminated, entered into a computer database, or otherwise utilized, in any form or by any means. For more information, please contact Safe Rhode Island at 401-222-7627.

INJURY IN RHODE ISLAND

Injuries are predictable and preventable. Public health seeks to prevent injuries before they happen by analyzing data that captures both injury prevalence information and the risk factors responsible for the onset of injury.

Figure 1

7 Leading Causes of Death, Rhode Island
1999 - 2002, All Races, Both Sexes

	Age Groups											
Rank	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Short Gestation 79	Unintentional Injury 8	Unintentional Injury 14	Unintentional Injury 12	Unintentional Injury 50	Unintentional Injury 59	Unintentional Injury 71	Malignant Neoplasms 279	Malignant Neoplasms 718	Malignant Neoplasms 1,324	Heart Disease 10,808	Heart Disease 12,308
2	Congenital Anomalies 54	Congenital Anomalies 6	Malignant Neoplasms 10	Malignant Neoplasms 9	Homicide 27	Suicide 31	Suicide 64	Heart Disease 179	Heart Disease 441	Heart Disease 815	Malignant Neoplasms 7,280	Malignant Neoplasms 9,698
3	Placenta Cord Membranes 24	Malignant Neoplasms 6	Homicide 4	Congenital Anomalies 2	Suicide 18	Homicide 24	Malignant Neoplasms 50	Unintentional Injury 111	Unintentional Injury 105	Chronic Low. Respiratory Disease 132	Cerebro-vascular 2,239	Cerebro-vascular 2,429
4	Maternal Pregnancy Comp. 16	Cerebro-vascular 3	Septicemia 3	Homicide 2	Malignant Neoplasms 7	Malignant Neoplasms 14	Homicide 39	Suicide 86	Liver Disease 95	Diabetes Mellitus 119	Chronic Low. Respiratory Disease 1,830	Chronic Low. Respiratory Disease 2,027
5	SIDS 14	Heart Disease 3	Congenital Anomalies 2	Influenza & Pneumonia 2	Congenital Anomalies 6	Heart Disease 8	Heart Disease 36	Liver Disease 57	Suicide 69	Liver Disease 100	Influenza & Pneumonia 1,172	Influenza & Pneumonia 1,256
6	Circulatory System Disease 13	Homicide 3	Five Tied 1	Suicide 2	Heart Disease 2	Cerebro-vascular 2	HIV 15	HIV 52	Diabetes Mellitus 62	Cerebro-vascular 95	Alzheimer's Disease 967	Diabetes Mellitus 1,056
7	Bacterial Sepsis 11	Benign Neoplasms 2	Five Tied 1	Two Tied 1	Meningo-coccal Infection 2	Congenital Anomalies 2	Influenza & Pneumonia 8	Homicide 36	Two Tied 47	Unintentional Injury 73	Diabetes Mellitus 852	Unintentional Injury 1,048

WISQARS™ Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

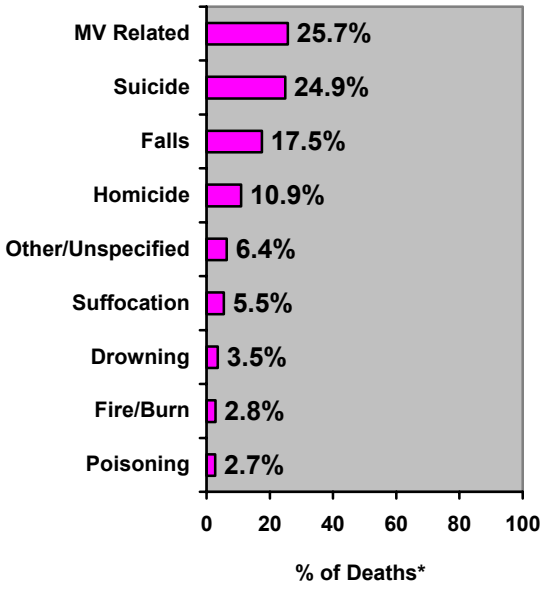
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Using a data driven approach, SRI in collaboration with the Injury Advisory Council, identified the top three injury focus areas based on information derived from Rhode Island Vital Statistics Data, Rhode Island Hospital Discharge Data, and other state-level injury data sources. The three injury focus areas are: unintentional falls, unintentional motor-vehicle

crashes, and suicide/self-harm, which combined, account for the greatest proportion of injury-related morbidity and mortality in the state (Figure 2, Figure 3).

Figure 2

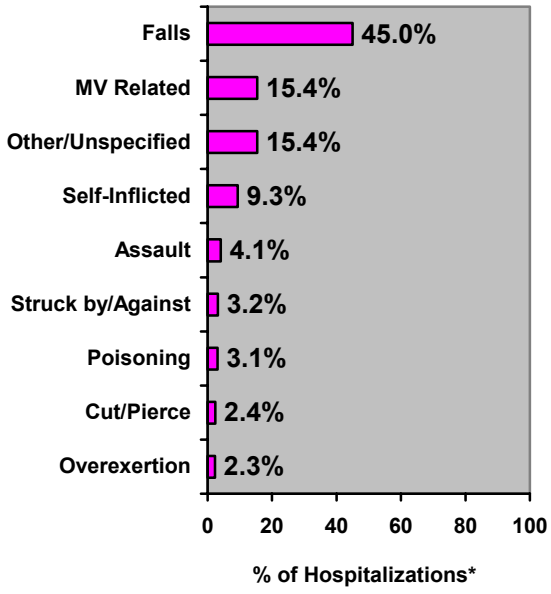
Top 9 Leading Causes of Injury-Related Death, Rhode Island, 1991-2002



*Percentages may not total 100 due to rounding
Source: National Center for Health Statistics, 1991-2002

Figure 3

Top 9 Leading Causes of Injury-Related Hospitalization Rhode Island, 1991-2002



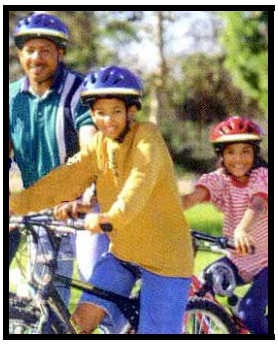
*Percentages may not total 100 due to rounding
Source: Rhode Island Hospital Discharge Data, 1991- 2002

What follows is a detailed description of the SRI injury prevention strategies and a description of the top three injury priority areas, including a brief data overview of the injury problem, and the shared prevention objectives recommended by both SRI and the community task forces for each priority area.

PREVENTION STRATEGIES

Public health is the ideal arena for injury surveillance and widespread prevention, because it addresses illness/injury at a population-level. HEALTH works with the community as a whole to successfully direct injury prevention efforts.

Injury prevention recommendations are based upon the most recent information available about the victims and consequences of injury in Rhode Island, with the purpose of informing and enhancing Health Department injury prevention efforts, as well as the efforts of our community collaborators. Recommendations are broad reaching and comprehensive to encourage implementation by as many key stakeholders in injury prevention as possible. Objectives and recommendations are not time framed in recognition of the fact that effective program implementation is often dependent on available resources.



SRI Task Force members have agreed to participate in the Injury Community Planning Group (ICPG) and will work with SRI to develop strategies to engage additional local partners (e.g., social service providers, civic groups, and businesses) in activities that build local capacity to conduct injury prevention interventions, and to promote injury prevention. Membership will be expanded to I agencies and organizations that have developed infrastructure and available resources, concentrating on ways to integrate injury prevention into existing program protocols.

Potential members include, community health centers, primary care providers, Principals, Superintendents, and School Nurse Teachers' Associations, EMS regulators, local fire and police departments, housing officials, recreation directors, city planners, home health care agencies, media representatives, worksites, sports groups, etc. The expanded membership of the Task Forces will constitute the ICPG. The ICPG will convene in fall of 2005 and will be charged with:

1) Developing and promoting a mission, vision and scope of work for SRI/ICIPCP
2) Developing funding strategies to support infrastructure and implementation of interventions.
3) Utilizing injury data reports to establish annual implementation priorities for the Plan.
4) Developing strategies to fund prioritized activities.
5) Planning an annual symposium in partnership with Lifespan Injury Prevention Center.

A community planning process will determine the highest-priority, population-specific prevention needs in the state, identify lead agencies responsible for addressing priority recommendations, and identify strategies to generate support and resources to fund injury prevention interventions.

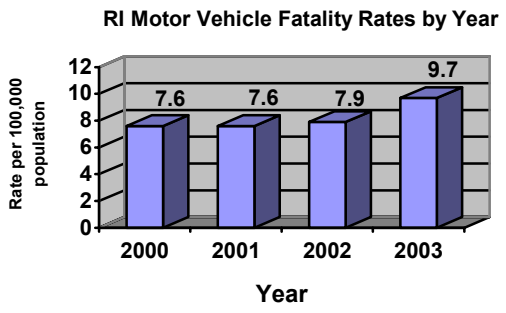
In summary, SRI will engage community partners in two key activities to move the state injury prevention plan forward: 1) Priority setting to make implementation more manageable; and 2) Developing funding strategies to support infrastructure implementation and interventions.

MOTOR VEHICLE/TRANSPORTATION INJURY PREVENTION

Prevent Motor Vehicle Crash Injuries and Deaths

Annually, over 90 people are killed on the state's roads [1]. Many more than that are hospitalized yearly due to an injury resulting from a traffic collision. The economic burden of motor vehicle crashes in Rhode Island is considerable, with costs reaching almost one-billion dollars during the year 2000 [4]. Motor vehicle crashes are the leading cause of death overall for state residents aged 10-34, and are the leading cause of unintentional injury death for Rhode Islanders ages 10-64[1]. Fatality rates in Rhode Island due to motor vehicle related injuries appear to be increasing (Figure 4). From 2002 to 2003, while 27 states showed fatality state decreases, Rhode Island was the second ranked with fatality increases (+24% change)[4].

Figure 4



Data Source: NHTSA, State Traffic Safety Information, 2003

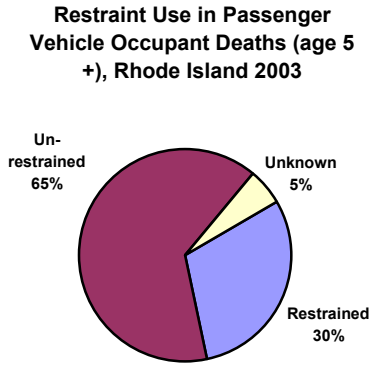
Seat Belt Laws and Seat Belt Use

In 2003, a full 65% of traffic fatalities in Rhode Island involved unrestrained motorists (Figure 5). Primary safety belt laws increase safety belt use and reduce traffic fatalities [5]. Rhode Island currently has secondary enforcement of safety belt laws. Unlike primary enforcement, which allows law officers to stop motorists for failing to wear a seat belt, secondary enforcement permits citation for failure to buckle up only when a driver is stopped for some other violation, such as a burned out tail light.

Drastic differences in safety belt usage rates are observed between states with primary verses secondary enforcement of safety belt laws. During the year 2003, the seat belt use rate in Rhode Island was only 74%, whereas in California, a primary safety belt law state, a full 91% of motorists wore their seat belt[4].

Among Rhode Island high school students the news is not good. A 2004 University of RI survey found that compared to the Rhode Island average, fewer high school students wear their seat belts while riding

Figure 5

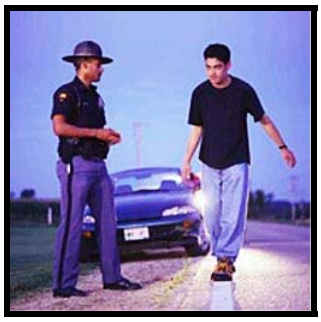


Data Source: NHTSA, State Traffic Safety Information, 2003

in a car, with only 69.5% of respondents reporting that they buckle up [6].

Alcohol Use

Alcohol use increases the risk of injuries. Alcohol has been a factor in a substantial proportion of the injuries and deaths from falls, homicide, suicide, and domestic violence, and is one of the key risk factors for motor vehicle crashes. In 2003, Rhode Island had the highest percent of alcohol-related fatal crashes in the country (55%), far surpassing the national figure of 40% [7]. Individuals under the age of 21 are more likely to be involved in fatal crashes compared to older adults [16]. Alcohol use increases their already high risk for sustaining a fatal motor vehicle related injury. According to a statewide survey of Rhode Island high school students, more than 33% reported riding in a car with a drinking driver, and one in five male students reported driving while they had been drinking [8]. Although nationally the largest decrease in alcohol-related fatal crashes appears among individuals under the age of 21 [16], the number of young Rhode Islanders reporting that they drink alcohol while driving remains alarmingly high.



Goal: Reduce deaths and injuries caused by motor vehicle crashes.

A Healthier Rhode Island by 2010 **Goal:** Reduce deaths caused by motor vehicle crashes from 9 per 100,000 to 7 per 100,000.

Key Groups: Males 16-34, senior adults, and minorities

Objective 1: Occupant Protection - Increase the percentage of people who always use safety belts and the percentage of children using age-appropriate child restraints and seated in the correct position in a motor vehicle.

1.1 Encourage the use of state-of-the-art technology in highway and motor vehicle design.

1.2: Provide public education for parents to support their children to be safe drivers, safe occupants, safe bicyclists, safe motorcyclists, and safe pedestrians a mandate parent component to driver education.

1.3: Provide community-wide information and enhanced enforcement campaigns for occupant protection.

1.4: Provide child safety seat incentive, distribution and education programs.

1.5: Provide education for commercial motor vehicle operators on seat belt use.

1.6: Utilize resources to promote the enforcement of existing safety belt child restraint.

1.7: Provide resources to enforce existing laws/targeted enforcement.

1.8: Strengthen current seat belt laws from secondary enforcement to primary enforcement.

1.9: Institute higher standards for driver education, licensing, and re-licensing.

1:10: Provide on-going education on motor vehicle laws for all drivers at re-licensing.

1.11: Collect, analyze, link and disseminate data on motor vehicle crashes specifically occupant restraint.

Objective 2: Speeding - Reduce the percentage of people who use excessive speed on Rhode Island roadways.

2.1: Encourage the use of state-of-the-art technology in highway and motor vehicle design.

2.2: Continue to improve the roadway environment to reduce excessive speed.

2.3: Identify and improve high-hazard intersections.

2.4: Provide public education for parents to support their children to be safe drivers, safe occupants, safe bicyclists, safe motorcyclists, and safe pedestrians and mandate parent component to driver education.

2.5: Provide community-wide information and enhanced enforcement campaigns.

2.6: Provide education for commercial motor vehicle operators on excessive speed.

2.7: Utilize resources to promote the enforcement of existing speeding laws.

2.8: Institute higher standards for driver education, licensing, and re-licensing.

2.9: Collect, analyze, link and disseminate data on motor vehicle crashes specifically speeding.

Objective 3: Impaired Driving - Reduce the number of medically impaired, alcohol-related, and fatigue impaired motor vehicle deaths and injuries.

3.1: Encourage the use of state-of-the art technology in highway and motor vehicle design.

3.2: Increase patient counseling on medication effects and interactions that may impair driving ability.

3.3: Increase health care professionals ability to assess impairment, facilitate counseling, and reporting to registry.

3.4: Provide senior adults information on potential problems due to physical limitations and on the best ways to improve their personal safety and mobility.

3.5: Retest the validity of sobriety checkpoints in Rhode Island and investigate legal changes to allow them if necessary.

3.6: Increase the number of patrol officers dedicated to DWI enforcement.

3.7: Strengthen penalties for refusal to submit to a chemical test.

3.8: Support health care professionals to report medical impairment, including substance abuse.

3.9: Provide on-going education on motor vehicle laws for all drivers at re-licensing.

3.10: Collect, analyze, link and disseminate data on motor vehicle crashes, specifically impaired driving.

Objective 4: Pedestrian - Reduce the number of pedestrian deaths and injuries.

4.1: Integrate pedestrian issues into transportation/land use planning to create and maintain safe and walkable communities.

4.2: Increase, improve and maintain signs and markings for drivers.

4.3: Provide funding for pedestrian infrastructure, such as sidewalks and crosswalks.

4.4: Train law enforcement personnel on traffic violations affecting pedestrian safety.

4.5: Provide public education for parents to support their children to be safe drivers and pedestrians, and mandate parent component to driver education.

4.6: Improve elder safety through awareness and retesting programs.

4.7: Provide resources to enforce existing laws / targeted enforcement.

4.8: Support the philosophy of police community involvement throughout RI.

4.9: Institute higher standards for driver education, licensing, and re-licensing.

4.10: Collect, analyze, link and disseminate data on motor vehicle crashes, specifically pedestrian related.

Objective 5: Bicycle - Reduce the number of bicycle-related deaths and injuries.

5.1: Incorporate bicycle lanes and off road paths into transportation/land use planning, especially in site selection for schools, recreation areas and play groups, when feasible.

5.2: Increase, improve and maintain signs and markings.

5.3: Provide funding for bicycle infrastructure, such as bicycle lanes and off road paths.

5.4: Train law enforcement personnel on traffic violations affecting bicycle safety.

5.5: Provide public education (e.g., public awareness campaign) for bicyclists and for parents to support their children to be safe bicyclists.

5.6: Train bicyclists about the proper use of engineering enhancements.

5.7: Support the philosophy of police community involvement throughout R.I.

5.8: Hold bicyclists accountable for safe, legal behavior.

5.9: Make bicyclists a police leadership priority.

5.10: Collect, analyze, link and disseminate data on motor vehicle crashes, specifically bicycle related injuries.

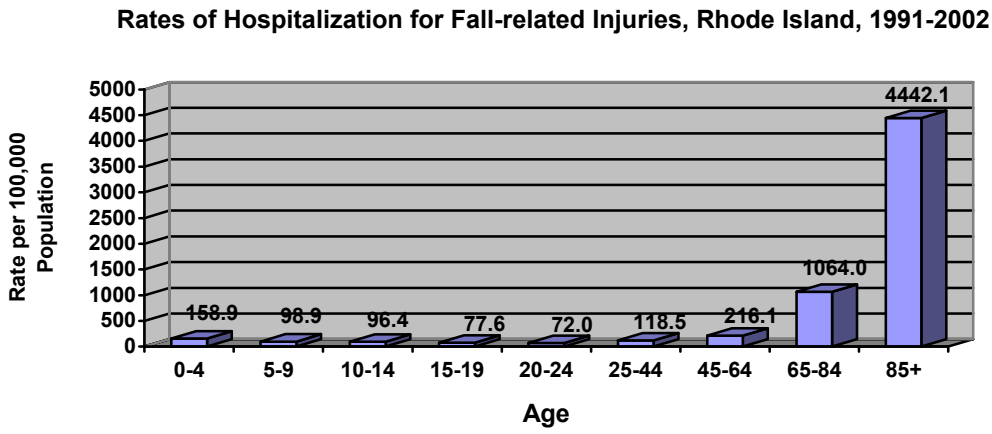
Objective 6: Motorcycle - Increase the percentage of operators and passengers who always use a motorcycle helmet.

6.1: Promote a universal helmet law.

FALL INJURY PREVENTION

Nationally, 30-60% of older adults (over 65) experience a fall each year [9, 10]. In 2000, 1.6 million senior adults in the United States were seen in emergency departments for injuries sustained from a fall[11]. Older adults are hospitalized for fall-related injuries five times more often than for other causes [11]. In Rhode Island, elders have by far the highest rates of fall-related hospitalization compared to all other ages (Figure 6). Falls are also the leading cause of injury-related death for Rhode Islanders over the age of 65[1]. Roughly 66% of all accidental deaths in this age group are caused by a fall-related injury [1]. Elder women are disproportionately affected by falls. For women over the age of 65, falls are the leading cause of injury hospitalization, accounting for 82% of the injury admissions in 2000 [11]. Factors that increase the risk of falling include lack of physical activity; use of multiple medications; certain health conditions; and environmental factors [11].

Figure 6

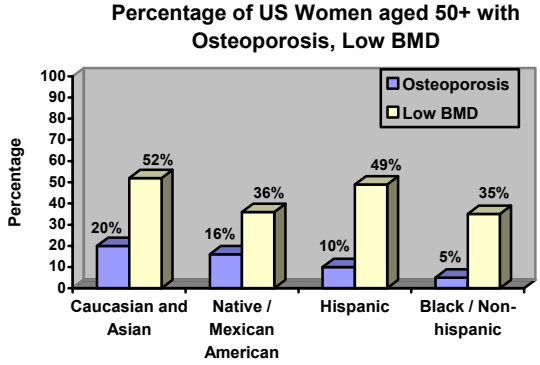


Data Source: Rhode Island Hospital Discharge Data, 1991-2002; data provided by the Rhode Island Office of Health Statistics

Figure 7

Prevent Falls and Hip Fractures in Women

Hip Fracture is the fall-related injury that causes the greatest number of deaths and institutionalizations [11]. Women are particularly susceptible, sustaining 80% of all hip fractures [12]. White, post-menopausal women have a 1 in 7 chance of fracturing a hip – reflecting higher rates of osteoporosis among this population (Figure 7). Only 25% of hip fracture patients survive their injury, while 24% of those over



Source: National Osteoporosis Foundation. 2002

age 50 will die within 12 months after sustaining their injury [13]. With the aging baby boom generation, the number of people aged 65+ is projected to increase from 39 to 70 million between 2010 and 2030 [11]. The problem of hip fractures is expected to increase dramatically with the rise in population of individuals over the age of 65.

Goal: Prevent falls and resulting injuries to senior adults living in the community

Healthy People 2010 **Goal:**
Reduce deaths from falls from 4.7 per 100,000 to 3.0 per 100,000.

Reduce hip fractures for females ages 65+ from 1,056 per 100,000 to 416 per 100,000 and for males 65+ from 593 per 100,000 to 474 per 100,000.

A Healthier Rhode Island by 2010 **Goal:** Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day from 22% to 30%.

Key Group: Senior adults (65-85+) living in the community

Objective 1: Increase the percent of senior adults who exercise on most days of the week to reduce the risk of falls and resulting injuries.

1.1 Increase awareness and knowledge of fall risk and protective factors related to physical conditioning.

1.2: Partner with existing agencies, health care providers, housing sites, businesses, and relevant university and other education programs to promote regular exercise and skills training to reduce falls and resulting injuries.

1.3: Promote the adoption of targeted home exercise programs to address identified risk factors.

1.4: Improve collection, analysis, and dissemination of data on the percent of senior adults who exercise.

1.5: Target senior adults who have had a recent fall.

Objective 2: Improve the safety of the physical environment in senior adult homes.

2.1: Increase awareness and knowledge of fall risk and protective factors related to the safety of the physical environment, including clothing and assistive devices, to improve safety in the physical environment.

2.2: Identify and promote standardized home falls risk assessments.

2.3: Increase knowledge of existing resources for home modification and assistive devices.

2.4: Increase resources for home modification and assistive devices.

2.5: Target senior adults who have had a recent fall.

2.6: Improve collection, analysis, and dissemination of data on the percent of senior adults who have home safety assessments

Objective 3: Improve the management of health conditions that place senior adults at increased risk of falls and resulting injuries.

3.1: Increase awareness and knowledge of fall risk and protective factors related to health conditions (e.g., osteoporosis, postural hypotension, and visual impairment).

3.2: Partner with local health care providers and payers to promote education, screening and management of health conditions that put senior adults at risk of falls and resulting injuries (e.g., decreased bone density, postural hypotension, and visual impairment).

3.3: Improve collection, analysis, and dissemination of data on the percent of senior adults who receive screenings for health conditions that place them at risk of falls and resulting injuries (e.g., decreased bone density, postural hypotension, and visual impairment).

Objective 4: Increase the percentage of senior adults who have medication reviews to promote medication management.

4.1: Partner with academic pharmacy programs, pharmacies, senior services, housing sites, and other injury prevention programs to promote regular medication reviews

4.2: Increase consumer awareness and knowledge of fall risk and protective factors related to medication use and other substance use (e.g., public education campaigns on how to talk to health care providers).

4.3: Partner with health care providers and health plans to promote medication review and management that reduces the risk of falls and resulting injuries.

4.4: Identify, review, and modify medication regimens that increase the risk of falls.

4.5: Improve collection, analysis, and dissemination of data on the percent of senior adults who have medication reviews

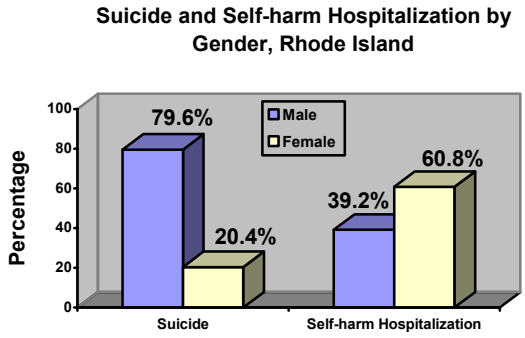
SUICIDE PREVENTION

Overall, suicide is the 11th leading cause of death in the United States, and the 3rd leading cause of death (after unintentional injuries and homicide) for ages 15-24 [1]. Nationally, during the year 2002, over 30,000 people died by suicide and approximately 250,000 people were either hospitalized or treated in an emergency department for a self-inflicted injury [14]. Nationally, suicide rates increase with age, peaking during adolescence and early adulthood[1]. More teenagers and young adults die by suicide each year than from cancer, AIDS, birth defects, and pneumonia combined [15]. Successful suicides are frequently preceded by multiple suicide attempts, making a previous suicide attempt one of the greatest risk factors for suicide completion [14].

Suicide in Rhode Island

Suicide is the leading cause of intentional injury death in Rhode Island [1]. For young Rhode Islanders (those 15-24 years old), suicide is the 3rd leading cause of death overall[1]. Almost four out of five (79.6%) suicides in the state occur among males, while just over 60% of hospitalizations for self-harm occur among females (Figure 8). Almost half (46%) of the total suicides in Rhode Island from 1999-2002 were committed by adults aged 25-44, and another 16.5% of suicides were committed by individuals aged 60 and older[1]. Statewide, self-inflicted death rates peak between the ages of 35 – 44 (Figure 9). These data informed the selection of key groups for suicide prevention in Rhode Island: males 25-45; youth 15-24; and senior adults 60 and older.

Figure 8

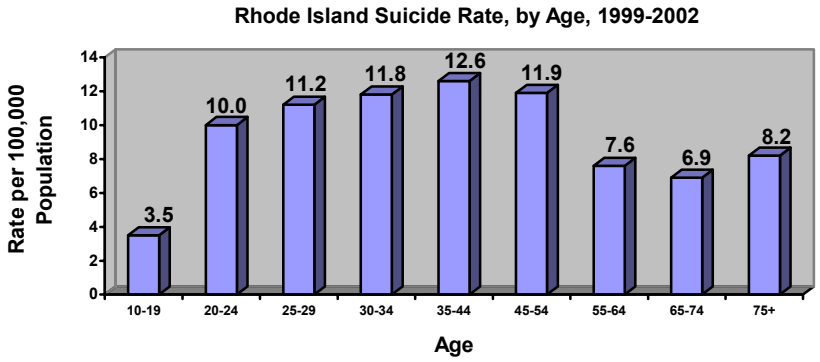


Data Sources: National Center for Health Statistics, 1991-2002; Rhode Island Hospital Discharge Data, 1991-2002

Among key risk factors associated with suicide and suicide attempt the Rhode Island plan addresses the following: mental and physical illnesses; substance/alcohol abuse; sexual abuse; and unemployment.

A detailed plan for youth suicide prevention titled, *A Suicide Prevention Framework For Rhode Islanders Ages 15-24,* was created by the RI Suicide Prevention Planning Team in 2002. The framework can be accessed at http://www.health.ri.gov/disease/saferi/suicide_preventsummary.php.

Figure 9



Data Source: National Center for Health Statistics, 1999-2002

Goal 1: Reduce the completed suicide rate

Goal 2: Reduce suicide attempts

***A Healthier Rhode Island by 2010* Goal:** Reduce the suicide rate from 10 per 100,000 to 4 per 100,000.

Key Groups: Youth 15-24, males 25-45, older adults 60+

Objective 1: (Awareness) To support and affirm people at-risk for death by suicide

Objective 2: (Awareness) To reduce the stigma associated with having a mental illness and/or seeking services for mental health, substance abuse, and suicide prevention

1.1 (2.1): Provide information to individuals and families that increases the acceptability of seeking services and reduces associated stigma.

1.2 (2.2): Teach, encourage, and reinforce emotional competence.

1.3 (2.3): Provide support groups that build a sense of community.

1.4 (2.4): Encourage a safe and nurturing living environment.

1.5 (2.5): Educate and assist family, friends, neighbors and others to understand who is at risk for suicide and how to respond to at-risk individuals.

1.6 (2.6): Increase awareness of community resources for suicide prevention and provide suicide prevention information on the web.

1.7 (2.7): Develop and promote use of common language/terminology related to suicide prevention.

1.8 (2.8): Raise awareness about the dangers of over-the-counter and prescription medications and other lethal means.

1.9 (2.9): Raise awareness that suicide is a public health problem and that it is preventable through early seeking of help from resources in the community.

1.10 (2.10): Conduct a statewide education campaign to increase the acceptability of seeking services and reduce associated stigma.

1.11 (2.11): Provide training and staff development around suicide issues in relevant community agencies and develop and promote cross-agency use of common language and terminology around suicide prevention.

1.12 (2.12): Improve referral knowledge, efficiency, and effectiveness by all who refer, starting with primary care providers.

1.13 (2.13): Develop partnership with media to provide guidelines on suicide reporting that decrease likelihood of suicide contagion.

1.14 (2.14): Partner with community, voluntary and faith-based agencies to increase awareness of services to individuals and families in need and promote suicide prevention.

1.15 (2.15): Partner with health care providers and insurers to improve access to services; i.e. Rite Care reimbursement, and private insurers.

1.16 (2.16): Increase delivery of effective suicide prevention education programs in organizations/places where individuals and families congregate.

1.17 (2.17): Develop criteria for an effective suicide prevention policy (including assessing situation, gun safety, etc.) and advocate for adoption in all healthcare organizations.

1.18 (2.18): Assure implementation of such policy and ongoing awareness of suicide prevention policy.

1.19 (2.19): Advocate for increased funding to deliver public awareness campaigns.

1.20 (2.20): Provide fact sheets to legislators.

1.21 (2.21): Advocate for adequate mental health service coverage.

Objective 3: (Intervention) To improve and expand mental health services delivery

3.1: Provide information to individuals on existing mental health services and how they can be accessed and paid for.

3.2: Promote and enhance initiatives that build mental health services capacity.

3.3: Provide initiatives to strengthen individuals' emotional competency.

3.4: Increase cross training of health and human services providers related to risk assessment, recognition, treatment management, and aftercare of suicidal individuals.

3.5: Educate providers about utilizing culturally appropriate interventions.

3.6: Improve access to services and reimbursements by building coalitions of state, local, and community-based agencies.

3.7: Partner with other state agencies to identify common areas of concerns related to mental health service needs of people under their care.

3.8: Work with community-based agencies to increase awareness of services to individuals and families in need.

3.9: Expand range of mental health providers eligible for reimbursement.

3.10: Strengthen resources for volunteer training to increase hotline availability.

3.11: Implement utilization management guidelines for suicidal risk in managed care and insurance programs.

3.12: Advocate for adequate reimbursement and coverage for universal, selected and indicated mental health services.

3.13: Encourage suicide prevention education for all providers seeking licensure.

Objective 4: (Intervention) To increase screening and identification of at risk individuals

4.1: Support and educate peers to identify emergency situations and at-risk peers.

4.2: Support peers who seek help for their at-risk friends.

4.3: Provide educational programs for family members of persons at elevated risk.

4.4: Educate clergy, primary care doctors, nurses, police and fire department personnel and "gatekeepers" to identify at-risk individuals.

4.5: Provide resources (referral information) to providers who identify at-risk individuals.

4.5: Screen early and often via primary care physicians, home care, school-based care and other health care providers/agencies.

4.6: Annually review data, and characteristics of completed and attempted suicides to improve screening tools.

4.7: Design instruments (prompts) for use by primary medical doctors to increase screening.

4.8: Assess and evaluate validity of existing screening tools to make good choice of tools.

4.9: Advocate for coverage and reimbursement for routine screening services.

Objective 5: (Intervention) To promote efforts to reduce access to lethal means and methods of self-harm

5.1: Raise awareness during legislation season about gun control bills.

5.2: Raise awareness through public education campaigns about gun safety measures and gun deaths in Rhode Island.

5.3: Educate providers about the relationship between substance use and other high-risk behaviors and suicide.

5.4: Educate health care providers and health and safety officials on assessment of lethal means in the home.

5.5: Establish interagency collaborations around support for gun control and gun safety.

5.6: Improve communication among providers of health care services.

5.7: Add gun issues to health care providers policy criteria.

5.8: Address suicide attempts by over-the-counter medications with providers and pharmacists; e.g. warning labels for RXs.

5.9: Advocate for gun control legislation using information on the relationship between a waiting period and suicide.

Objective 6: (Methodology) To coordinate and expand public health surveillance of suicide and suicide attempts

6.1: Establish objectives of a public health surveillance system for suicide and suicide attempts.

6.2: Develop case definitions for suicide and suicide attempts.

6.3: Using CDC criteria determine the utility and feasibility of various data sources or data collection mechanisms for the surveillance of suicides and suicide attempts among Rhode Islanders (Medical Examiner Files, Hospital Discharge Data, Emergency Department Data, Emergency Medical Service run reports, Poison Center Data, School-Based Health Center Data, Child Death Review Team database).

6.4: Develop data collection instruments if not already developed.

6.5: Develop field test methods.

6.6: Develop and test analytic approach.

6.7: Develop dissemination mechanism.

6.8: Support use of analysis and interpretation.

Objective 7: (Methodology) To promote and support culturally relevant research on suicide and suicide prevention

7.1: Research and evaluate the potential role and effectiveness of conducting psychological autopsies in Rhode Island

7.2: Research the effectiveness of treatments for suicidal risk.

7.3: Review literature on the impact of emotional competency/character education etc. on suicide and suicide attempts or affiliated risk behaviors (e.g. dropping out of school, getting into trouble, etc.

7.4: Evaluate the impact of existing primary prevention programs (e.g. emotional competency, character education, and social/emotional education) on suicide and suicide attempts at Rhode Island hospitals.

7.5: Evaluate the accuracy of E-coding (categorizing of injuries and intent) suicide attempts at Rhode Island hospitals.

7.6: Evaluate outcomes of students referred by counseling and support services.

7.7: Support molecular biology/genetics research and the potential link to suicide.

7.8: Conduct bio-psychosocial research on causes and prevention of suicide.

7.9: Evaluate suicide prevention interventions.

7.10: Clarify risk and protective factors specific to different populations (demographics, SES, religion, participation in extra-curricular activities, etc.)

INFRASTRUCTURE

Objective 1: Improve the capacity of Rhode Island to support injury prevention interventions.

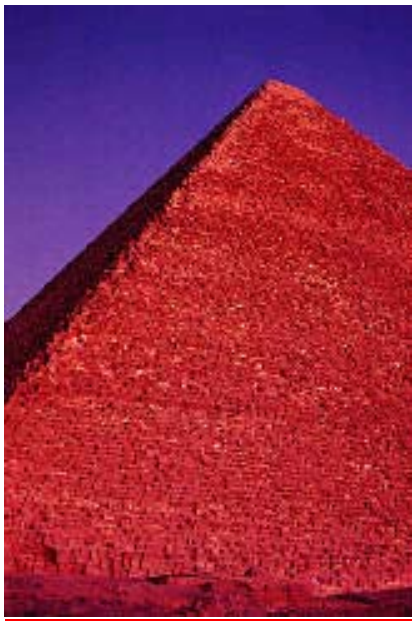
The following recommendations will facilitate the identification of state and partner infrastructure to support statewide injury prevention efforts:

1.1: The Motor Vehicle/ Transportation, Suicide, and Fall Injury Prevention Task Forces will re-convene in fall 2005 as part of the Injury Community Planning Group (ICPG) of the Integrated Core Injury Prevention and Control Program (pending continued CDC funding).

1.2: The ICPG, with the oversight of the Rhode Island Department of Health, will further delineate roles to support the development and implementation of infrastructure recommendations.

1.3: The Rhode Island Department of Health will develop a management / monitoring structure to continuously assess progress towards meeting injury prevention objectives, and to seek resources to support implementation.

1.4: The Rhode Island Department of Health and the Injury Prevention Center (Lifespan), through an ICPG Symposium, will provide a forum to report on the status of injury prevention objectives and recommendations, and obtain community input on the development of marketing and funding strategies.



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